

WAIVER OF HOSPICE OR HOME HEALTH SERVICES BY A TERMINALLY ILL CBRF RESIDENT

Completion of this by form by the resident is voluntary HFS83.34(2)2.

Name – Resident		Date
Name – CBRF		
Address	City-State-Zip Code	Telephone Number

A terminally ill resident of a CBRF may waive the requirement that he or she receive the services of a Hospice Program or a Home Health Agency for his or her terminal illness while continuing to reside in the CBRF. It is important for the resident or his or her guardian or agent to make an informed decision on whether or not to waive services from these agencies. An agent of the resident can be the person designated in the power of attorney for health care document that has been activated. (This may include durable power of attorney documents that gave health care decision making powers to an agent.) Therefore, prior to waiving these services, the CBRF must ensure that the resident and his or her guardian or agent are provided with information about the type of services generally offered by a Hospice Program or Home Health Agency. The CBRF must provide an opportunity to:

1. Speak with a representative of a Hospice Program or Home Health Agency.
2. Review literature for a Hospice Program or Home Health Agency which describes its services to a terminally ill person.

If the services of a Hospice Program or Home Health Agency are waived by the resident or his or her guardian or agent, the CBRF is required to coordinate all of the care and services for the terminally ill resident.

The resident or the resident and his or her designated representative, or his or her guardian or activated health care agent may, at any time, revoke this waiver and receive services from a Hospice Program or Home Health Agency by signing the Revocation of Waiver on the other side of this form.

Having been provided the opportunity to speak with a representative of a Hospice Program or Home Health Agency, and review literature from at least one of these agencies, I hereby waive the services of a Hospice Program or Home Health Agency.

SIGNATURE - Resident (and designated representative, if previously requested by resident in writing)	Date Signed
or SIGNATURE - Guardian or Agent	Date Signed

REVOCATION OF THE WAIVER OF HOSPICE OR HOME HEALTH SERVICES

I hereby revoke the waiver on the opposite side of this form
so that I may receive the services of a Hospice Program or Home Health Agency.

SIGNATURE – Resident (and designated representative, if previously requested by resident in writing)	Date Signed
OR SIGNATURE - Guardian or Agency	Date Signed